GEORGIA ATHLETIC AND ENTERTAINMENT COMMISSION
2 MARTIN LUTHER KING JR DR SUITE 814
ATLANTA GA 30334
TELEPHONE (404) 656-2868 FACSIMILE (404) 463-3480

COMPREHENSIVE
PHYSICAL EXAMINATION REPORT
PROFESSIONAL BOXER/UNARMED COMBATANT
MALE FEMALE

_____/_____/_____
Name Ring Name (Telephone) Date of Birth

_____
Address (street) (city) (state) (zip code)

PHYSICAL HISTORY: Has applicant ever had any of the following conditions:

Fainting spells	Rupture (hernia)	Chest pains	Operations
Shortness of breath	Swollen joints	Rheumatism	Diabetes
Frequent headaches	Convulsions (fits)	Chronic cough	Bleeding Disorder
Spitting of blood	Cerebral hemorrhage or any other serious head injury		

Number of knockouts received_____ Date of last knockout _____

Longest duration of unconsciousness_____

Length of time before resuming boxing after last knockout _____

Ever knocked unconscious in other sport or in any other way ? Yes No
If yes, explain _____

Does the applicant have a history of seizures?____

If so, when was the last time the applicant had a seizure? ____

Does the Applicant have a history of high blood pressure? ____

If so, do they have a primary care physician?____ Is the high blood pressure under control? ___

Amateur boxing record Wins _____ Losses _____ Draws _____

Professional boxing record Wins _____ Losses _____ Draws _____

PHYSICAL EXAMINATION:

General appearance _____ Height _____ Weight _____ Temperature _____

Disabling scars _____Mouth _____ Teeth _____Tonsils _____ Neck _____

Pulse at rest _____ Blood pressure at rest _____

Pulse after 100 hops _____ Blood pressure after 100 hops _____

Blood pressure 2 minutes later _____

Enlarged glands: ☐ Yes ☐ No Goiter: ☐ Yes ☐ No

Heart: Pulse rhythm ☐ Regular ☐ Irregular Apical impulse ☐ Heavy ☐ Normal

Enlargement ☐ Yes ☐ No Murmurs ☐ Yes ☐ No

Lungs: Rales ☐ Yes ☐ No

Breasts: Mass ☐ Yes ☐ No Tenderness ☐ Yes ☐ No

Discharge ☐ Yes ☐ No

Abdomen: Enlargement of liver ☐ Yes ☐ No Enlargement of Spleen ☐ Yes ☐ No

Hernia ☐ Yes ☐ No ☐ Femoral ☐ Inguinal ☐ Ventral

Testicles: Normal ☐ Yes ☐ No Remarks:_____

Reflexes: Pupils _____ Knee jerks _____ Romberg _____ Babinski _____

Skin: Rash _____ Boils _____ Any other unhealed wounds:_____

ADDITIONAL REQUIREMENTS FOR AN APPLICANT WHO NEEDS SPECIAL PERMISSION FROM THE COMMISSION:
1.Electrocardiogram (attach tracings, if required by doctor)
_____
2. SEROLOGY: The original lab report with applicant's name and date the tests were performed must be submitted.

All tests must be within normal limits to meet the Nevada licensing requirements.

A. HIV

B. Hepatitis B Surface Antigen - - If positive confirmation by Neutralization technique. In certain situations a Hepatitis B Core Antibody test will be acceptable as confirmation.
C. Hepatitis C Antibody - If positive confirmation by qualitative PCR (polymerase chain reaction)
D. CBC _____
E. Chemistry panel including - Electrolytes _____ Creatinine _____ Liver function _____

PHYSICAL EXAMINATION COMPREHENSIVE REPORT - PAGE TWO

EYE HISTORY: Has applicant ever had any of the following conditions:

(1) Blurred vision ? ☐ Yes ☐ No

(2) Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye ? ☐ Yes ☐ No

(3) Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, or dislocated lens ? ☐ Yes ☐ No

YOU MUST ALSO GO TO AN OPHTHALMOLOGIST FOR A DILATED EYE EXAMINATION

EXAMINING PHYSICIAN: - The following section must be completed.

I have evaluated the above named athlete and ordered the requested exams. Listed are any significant abnormalities either in my physical or the testing. Also

listed are the steps I took to clarify any problem.

_____
_____
_____

PLEASE CHECK ONE: ☐ I HAVE ☐ HAVE NOT MEDICALLY CLEARED TO FIGHT

_____

LICENSED PHYSICIAN'S NAME AND LICENSE NUMBER (please print) PHYSICIAN'S SIGNATURE

_____

STREET ADDRESS DATE

( )

CITY STATE ZIP CODE PHONE NUMBER

_____

I declare under penalty of perjury under the laws of the State of Georgia, that the foregoing information is true & correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I hereby AUTHORIZE the Georgia Athletic and Entertainment Commission of the State of Georgia (the "Commission"), to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a professional unarmed combatant which may be contained in any of the Commission's records. I further authorize the Commission to release this information to any person whom the Commission determines has a need to know. I agree that I will fully cooperate with the Commission in making my medical history available including, but not limited to, giving oral or written reports to the Commission regarding my medical condition, care and/or treatment.

I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE the Commission on the basis of its attempts to obtain any of the foregoing information, and I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE any persons, firms, institutions or agencies providing such information to representatives of the Commission on the basis of its disclosures. I have signed this Release voluntarily and of my own free will.

I further agree that a photographic copy of this Authorization shall be valid as the original.

_____

DATE SIGNATURE OF APPLICANT

_____

LOCATION NAME PRINTED

Georgia Athletic and Entertainment Commission

MRI/MRA Requirements

MRI of Brain without contrast

MRI scan is to be performed on a 1.5 Tesla MR machine with capabilities including fast spin echo and FLAIR imaging.

Image sequences should include axial T1, T2, and FLAIR images; coronal images should be performed as a T2 coronal; and a single sagittal T1 sequence.

MRA of Brain

MRA scan is to include left and right internal carotids, vertebral and basilar arteries as well as the Circle of Willis.

Pursuant to NAC 467.027 the MRI/MRA requirements are listed above. Please take this notice to the radiologist to perform the tests to our specifications.

Please have the radiologist fax immediate reports to the Georgia Athletic and Entertainment Commission at 404-463-3480 and Dr.??????? , Ringside Physician for GAEC

If possible, please place images on a CD and forward to the Georgia Athletic and Entertainment Commission, 2 Martin Luther King Jr. Dr. Suite 814 Atlanta GA 30334

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OPHTHALMOLOGIC EXAM

FOR PROFESSIONAL BOXER/UNARMED COMBATANT

EXAMINATIONS DONE BY AN OPTOMETRIST WILL NOT BE ACCEPTED

_____/___/_____
Full Name: First Middle Last Ringname (Telephone) Date of Birth

_____
Address (street) (city) (state) (zip code)

HISTORY - If possible provide the following information:
Name and hometown of physician in charge: _____

Has applicant ever had any of the following conditions:
(1) Blurred vision ? ☐ Yes ☐ No

(2) Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye ? ☐ Yes ☐ No If yes, please explain:_____
_____

(3) Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract? ☐ Yes ☐ No If yes, please explain:_____
_____

(4) Eye Disease? ☐ Yes ☐ No
List nature of diseases or injuries: _____

(5) Eye Injury? ☐ Yes ☐ No
List nature of diseases or injuries: _____

(6) Detached retina surgery on either eye? ☐ Yes ☐ No

List which eye and when and where surgery was done: _____

EXAMINATION

VISION: Without / With Glasses REFRACTION: If either eye is 20/60 or worse:

Right _____/_____ Right ___ Sph___ Cyl x_____Acuity_____

Left _____/_____ Left ___ Sph___ Cyl x_____Acuity_____

Remarks: _____

Intraoccular Right_____mmHg
Tension Left_____mmHg
Motility Normal _____ Abnormal _____
Binocular Vision Normal _____ Abnormal _____

SLIT LAMP EXAM	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Conjunctiva _____	_____/_____	_____/_____	_____
Cornea_____	_____/_____	_____/_____	_____
Iris/Pupil_____ _	_____/_____	_____/_____	_____
Lens_____	_____/_____	_____/_____	_____
Eyelids_____	_____/_____	_____/_____	_____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL Right/Left	ABNORMAL Right/Left	ABNORMALITIES
Disc_____	___/___	___/___	_____
Macula_____	___/___	___/___	_____
Vessels_____	___/___	___/___	_____
Peripheral Retina_____	___/___	___/___	_____

PHYSICIAN'S REMARKS:

_____
_____
_____

(PLEASE READ AND SIGN ON REVERSE SIDE OF EXAM)

OPHTHALMOLOGIC EXAM - Page Two

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER/UNARMED COMBATANT BY AN OPHTHALMOLOGIST

Physicians Remarks:

_____
_____
_____

The commission shall deny, suspend, revoke, or place restrictions on the license of a professional or amateur boxer or martial arts fighter because of a medical or visual condition, including but not limited to one of the following:

1. ***Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes;***
2. ***Corrected visual acuity of less than 20/60 in either eye, regardless of its cause;***
3. ***A visual field of 60 degrees or less extending over one or more quadrants of the visual field;***
4. ***Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an ophthalmologist specified by the commission who then assesses that the boxer is at no significant risk of further injury to the retina if boxing is resumed. Such assessment shall occur both within five days before and five days after the contest;***
5. ***Presence of primary or secondary glaucoma, whether or not such condition has been treated;***
6. ***Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye;***
7. ***Any other visual condition which the commission determines would prevent the applicant or licensee from safely engaging in boxing activities.***

The examining physician is requested to mail a copy of any report, directly to the commission of an applicant that has a condition that may preclude him/her from being licensed.

PHYSICIAN:

I have read the above criteria and, in accordance with the vision requirements as

stated therein, have examined the applicant named on the other side of this form and I DO NOT FIND DO FIND a condition that would preclude him/her from being licensed as a professional boxer, or an unarmed combatant.

LICENSED PHYSICIAN'S NAME AND LICENSE NUMBER (please print) PHYSICIAN'S SIGNATURE

STREET ADDRESS DATE

CITY STATE ZIP CODE ( ) PHONE NUMBER

APPLICANT:

I declare under penalty of perjury under the laws of the State of Nevada, that the foregoing information is true & correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I hereby AUTHORIZE the Athletic Commission of the Department of Business and Industry of the State of Nevada (the "Commission"), pursuant to the provisions of NRS/NAC Chapter 467, to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a professional unarmed combatant which may be contained in any of the Commission's records. I further authorize the Commission to release this information to any person whom the Commission determines has a need to know. I agree that I will fully cooperate with the Commission in making my medical history available including, but not limited to, giving oral or written reports to the Commission regarding my medical condition, care and/or treatment.

I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE the Commission on the basis of its attempts to obtain any of the foregoing information, and I further RELEASE, PROMISE TO HOLD HARMLESS, and COVENANT NOT TO SUE any persons, firms, institutions or agencies providing such information to representatives of the Commission on the basis of its disclosures. I have signed this Release voluntarily and of my own free will.

I further agree that a photographic copy of this Authorization shall be valid as the original.

Date Signature of Applicant

Location Name Printed